Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
PO BOX 24809
HOUSTON TX 77029

Respondent Name
HARTFORD INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-11-4403-01

MFDR Date Received
AUGUST 1, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has sent a status request and a request for reconsideration, which have not been replied to. Therefore does not give us an avenue to properly seek reimbursement for services we provided. This is also in violation of Rule 133.240…"

Amount in Dispute: $75.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider represents that it faxed 2 pages to 210-403-9621 at 5:36 p.m. on December 23rd. It then represents that it faxed 3 pages to 512-341-7517 at 3:21 p.m. on March 31st. It then represents that it faxed 6 pages to 512-341-7517 at 5:36 p.m. on June 15th. Rule 133.20(b) provides that healthcare provider shall not submit a medical bill later than the 95th day after the date of service. The provider submitted its original medical bill and request for reconsideration by facsimile to 512-341-7517 on March 31st and June 15th. Since the provider submitted it original medical bill to 512-341-7517 more than 95 days after the date of service, the carrier is not liable for the provider's request for reimbursement and the provider's request for medical dispute resolution should be dismissed…"

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 19, 2010	CPT Code 96102	$75.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers'

compensation medical bills for reimbursement.

3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 28 Texas Administrative Code §134.600 sets out the guidelines for certain healthcare requiring preauthorization.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 19, (197) – Precertification/authorization/notification absent.

Issues

1. What is the timely filing deadline applicable to the medical bills for the service in dispute?
2. Did the requestor submit a preauthorization approval for the service in dispute?
3. Did the requestor forfeit the right to reimbursement for the service in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." The carriers' representative states in their position summary that "The provider submitted its original medical bill and request for reconsideration by facsimile to 512-341-7517 on March 31st and June 15th." However the respondent does not explain the medical bill submitted to Gallagher Bassett Services in San Antonio at facsimile number 210-403-9621 on December 23, 2010. The date of service is October 19, 2010, the requestor submitted a fax confirmation sheet which shows the bill was faxed to Gallagher Bassett at 210-403-9621on December 23, 2010; therefore, the bill was sent timely to the carrier.
2. The requestor in this dispute did not submit explanation of benefits for the disputed date of service. The insurance carriers' representative submitted an explanation of benefits dated July 12, 2011 denying services using denial code "19, (197) – Precertification/authorization/notification absent." CPT Code 96102 is defined as "psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face." In accordance with 28 Texas Administrative Code §134.600(p)(7), non-emergency health care requiring preauthorization includes all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program. Review of the documentation submitted by the requestor finds no preauthorized or Division exempted return-to-work rehabilitation program or a preauthorization approval to support the billed services.
3. Therefore, pursuant to 28 Texas Administrative Code §134.600(p)(7), the requestor in this medical fee dispute has forfeited the right to reimbursement due to lack of preauthorization for the services in dispute.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 28, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.